STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G496	B. WING		10/21/2014
NAME OF P	DOMINED OD GUDDU IED		STREET .	ADDRESS, CITY, STATE, ZIP CODE	•
NAME OF P	PROVIDER OR SUPPLIER		2333 W	/ESTDALE CT	
	STA PROGRAMS I		KOKON	MO, IN 46902	
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
W000000					
			W000000		
	This visit was for	r a fundamental	1100000		
	100011111101110111 all	d state licensure survey.			
	Dates of Survey:	September 24, 25,			
	October 15 and 2				
		21, 2017.			
	Facility number:	001010			
	Provider number				
	AIM number: 10				
	ZALIVI HUHHUCI. TU	00 2 73070			
	Surveyor: Ambe	er Bloss, QIDP			
	The following fe	deral deficiencies also			
	_	ings in accordance with			
	460 IAC 9.	ings in accordance with			
		completed 11/5/14 by			
	· •	_			
	Dotty Walton, Q				
	Shackelford, QII	Jr.			
W000149	483.420(d)(1)				
VVUUU 148	STAFF TREATME	ENT OF CLIENTS			
		evelop and implement			
		d procedures that prohibit			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING OO COMPLETED			
		15G496	B. WIN			10/21/2014	
NAME OF F	PROVIDER OR SUPPLIER	<u>. </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					VESTDALE CT		
BONA VI	STA PROGRAMS	INC		KOKON	MO, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (COMPLETION
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION) mistreatment, neglect or abuse of the client.			TAG	DEFICIENCY)		DATE
	inistreatment, neg	nect of abuse of the chefit.	l wo	00149	Toensure that established		11/20/2014
	Based on record	review and interview,	"	00147	agency policies and		11/20/2014
		d to implement and/or			procedures for investigation	ons	
		neglect policy to			andincident reporting are		
		stigate and prevent falls			being implemented and		
		ies for a client with a			executed as written, the		
	1	or 1 additional client			following corrective action	(s)	
	(#7).	or radditional ellent			will be implemented:	(3)	
	(117).				1) Allstaff located at 233	13	
	Based on record	review and interview,			Westdale Court (Westdale	,3	
		d to implement and/or			group home) will be		
		e/neglect policy to report,			re-trainedon the agency		
	_	stigate and prevent client			Personnel Policies and		
	to client abuse for	-			Procedures, Policy III:13:		
		t reports for client to			IncidentReporting. Complet	ted	
		1 of 4 sampled clients			Record of Trainings will be		
	(#1) and 1 additi	•			obtained and submitted		
	(#1) and 1 additi	tonar enem (#7).			uponcompletion of training.		
	Based on record	review and interview,			Refer to Appendix A for	•	
		d to implement and/or			Record of Trainingform to	he	
	I	e/neglect policy to			used.		
	_	stigate an injury of			2) Allinvestigations will	be	
		for 1 of 1 BDDS (Bureau			conducted in the manner		
		al Disabilities Services)			outlined on the		
	_	of unknown origin for 1			Residential Services		
	of 4 sampled clie	_			Investigation Process. Refer	,	
	or 4 sampled en	ents (na).			to Appendix B for process		
	Findings include	··			outline. To ensure that all		
	1 mamgs merade	••			investigations are conducted	l in	
	1) On 9/25/14 at	3:45 PM, the facility's			a uniform and consistent		
	,	of Developmental			manner, all Residential Hou	ise	
	`	rices) and internal			Managers, Qualified	130	
		reports from 6/1/14 to			Development Disability		
		Cports 110111 0/1/14 to			Development Disability		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUT	A. BUILDING 00		COMPLETED	
		15G496	B. WIN			10/21/2014	
NAME OF P	PROVIDER OR SUPPLIER)	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	KOVIDEK OK SUPPLIER			2333 W	ESTDALE CT		
	STA PROGRAMS I	-			лО, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
IAG		,	+	IAG	,	DATE	
		viewed. A BDDS report			Professionals, Nurses, the		
		icated "[Client #7] was			Director, and the Residential		
		seum] with other			Services Coordinator will be		
		staff was walking			trained on the newly		
	_	oit. Staff was assisting			establishedinvestigation		
	_	oing up a ramp when			process outline. Refer		
		ed a step and fell			toAppendix C for Record of		
		her face on part of the			Training form to be used in		
	i i	ooked like fake rock).			documenting training.		
The EMT (emergency medical				3) Toensure that all			
	technician)'s were called and she was				incidents of significant injur	Ty,	
	transported with	staff to [hospital] via			injury of unknown origin,		
	ambulance. Hou	use manager and			andpeer-to-peer aggression	are	
	residential nurse	were notified			properly documented and		
	immediately." T	The report indicated	investigated. Any incidentswill			vill	
	"[Client #7] had	a CT (computerized	be reported to the Residential			al	
	topography) scar	n, and required 6 stitches	Services Coordinator. The				
	which went from	n the bottom of her lip up	ResidentialServices				
	to her nose. She	has two fractures, one in			Coordinator will complete the	he	
	the nasal cavity	and one in the sinus			appropriate documentation and		
		expected to heal on their	maintainfor record keeping				
	_	rt indicated "[Client #7]			purposes. Refer to Appendix	D	
	•	antibiotics for the next			to review forms that will be		
	-	wear her dentures for the			implemented occurrences o		
		s to have soft foods only			eitherincident.		
	•	and cannot smoke or			4) Lastlyto ensure that		
	_	The attending physician			incidents have been reported	i	
		y follow up at this time,			and investigated in the man		
		cription of nicotine			asoutlined in agency policie		
	-	eport indicated "staff will			all investigations packets,	~,	
	•	itor [Client #7]'s injuries			regardless of type, will have	an	
		hanges in them to the			investigation process checkl		
		_			included. The checklist will		
		l, follow up with her					
	i primary care bhy	ysician will be done to			becompleted by the		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G496	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/21/2014
	PROVIDER OR SUPPLIER		STREET . 2333 W	ADDRESS, CITY, STATE, ZIP CODE VESTDALE CT MO, IN 46902	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION (X5) D BE COMPLETION DPRIATE DATE
TAG	check the progreinjuries/healing, [Client #7] has." A BDDS report "[Client #7] was with her housem picnic and taking downtown area. #7] tripped over her elbow. Staff and continued w 20 minutes later, which time she was take (emergency room nurse and QDDF Developmental I were notified im indicated all labs normal limits at Client #7 "had a which showed the present that the I consistent with a elbow." The repup with orthoped recommended for [Client #7] is to except when show up with [orthoped].	dated 8/8/14 indicated out in the community ates and staff, having a g a walk around the During the walk, [Client a curb and fell, scraping administered first aid alking for a bit. About she began to collapse, at was assisted to the port indicated "the called as a precaution, en to [hospital] ER en) as a precaution. The O (Qualified Disabilities Professional) mediately." The report is and x-rays were within the hospital except x-ray of her right elbow that there was some fluid Dr. (doctor) felt may be a hairline fracture of her ort indicated "A follow dic [doctor] is or 4 days from now. wear a sling at all times wering until she follows dic doctor]. It is also	TAG	Residential Services Coordinator as he/she is conducting theinvestigat Upon the conclusion of investigation, all investigationmaterials including the checklist v given to the Vice Presid ofResidential Services for review. The Vice Presid Residential Serviceswill sign-off on the checklist accompanying materials all items havebeen revie and approved. Refer to Appendix E to review investigation process checklist.	tion. the vill be ent or ent of and once
	recommended th	at [Client #7] follow up			

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	OF CORRECTION OF CORRECTION 15G496	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/21/2014
	PROVIDER OR SUPPLIER ISTA PROGRAMS INC	2333 W	ADDRESS, CITY, STATE, ZIP CODE L'ESTDALE CT MO, IN 46902	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	COMPLETION
	with [doctor] in 5 days. Due to the fact that [Client #7] has fallen 2 times in the last month the nurse is asking her physician for a PT evaluation. At this point in time, based on the tests that were ran, we do not see anything that points to a medical condition that would be contributing to her falling. She is scheduled to see [doctor] (ophthalmologist) on 8/11/14 @ (at) 10 am. This visit should be able to determine whether or not her vision is the cause of these falls. [Client #7]'s gait is normally steady." The report indicated "also, her ears were checked at the ER and there was no ear infection or fluid accumulation present." On 10/15/14 at 4:10 PM, record review indicated Client #7's diagnoses included, but were not limited to, intellectual disabilities, seizure disorder, and hydrocephalus (excessive water on the brain). Record review indicated Client #7 had a fall risk plan dated 11/26/13 and revised date 10/1/2014 which indicated Client #7's "diagnosis of Hydrocephalus and Cataracts cause her experience poor balance and little depth perception. She needs assistance walking on uneven, slick or graduated surfaces. She does not like walking in the winter time when snow and ice are on the ground. She will often refuse to walk on grass and find a path			

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Event ID:

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
11112 12111	or confidence.	15G496		LDING		10/21/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ESTDALE CT		
BONA VI	STA PROGRAMS I	NC		KOKOM	1O, IN 46902		
(X4) ID				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI			(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTI CROSS-REFERENCED TO DEFICIENC		HE APPROPRIATE	
TAG		nce no matter how much		TAG			DATE
		alk to her destination."					
		n indicated "[Client #7]					
	•	ker now to assist her in					
	_	le walking. She is to use					
	this whenever sh	e is outside of the					
	home." No furth	er documentation was					
	available to indic	cate Client #7's 7/5/14					
	_	thoroughly investigated.					
		nentation was available					
	to indicate correc						
		vent recurrence of falls					
		Client #7's 7/5/14					
	reported fall.						
	On 10/15/14 at 1	2:25 PM, the					
		dicated Client #7's team					
	wanted to rule or	ut medical causes of falls					
	after the 8/8/14 r	reported fall. The					
	Administrator in	dicated Client #7 had her					
	1	ecked, has had physical					
		seen her primary care					
		Administrator indicated					
		estigations of Client #7's					
	falls with major	ınjury.					
	2) On 9/25/14 a	t 3:45 PM, the facility's					
	· ·	of Developmental					
	,	ices) and internal					
		eports from 6/1/14 to					
		viewed. An internal					
	accident/inciden	t report dated 7/23/14					
	-	nt #1] was sitting on					
	couch watching	tv (television) and other					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		15G496	B. WIN			10/21/2014	
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFEIER			2333 W	ESTDALE CT		
	STA PROGRAMS I				1O, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE	
IAG		· · · · · · · · · · · · · · · · · · ·		TAG		DATE	
		acuuming and tired (sic)					
	_	#1] and she wouldn't so					
		hit her on her left upper					
		dness and may cause					
	_	orther documentation was					
		iew to indicate which					
	"other consumer	" hit Client #7.					
	An internal accid	dent/incident report dated					
		"[Client #7] was pushed					
		her left side. There is no					
		at this time." The report					
		who pushed Client #7.					
	ara not maicate	who pushed elient "7.					
	Both reports ind	icated "REPORT MUST					
	BE TURNED IN						
	BUSINESS DA						
	ACCIDENT/INC						
	SUPERVISOR A						
		report indicated the					
		llowing as have reviewed					
		rvisor, Agency Nurse,					
	, , ,	d Developmental					
		essional), Vice President,					
		es, Safety Manager,					
	1	tor, and President. No					
		tation was available for					
		dicated the incidents of					
		buse were reported to the					
	state agency BD	DS.					
	During an interv	riew on 10/15/14 at 2:35					
	PM, the facility	Administrator indicated					
	it is the facility p	policy that all incidents of					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G496		LDING	NSTRUCTION 00	(X3) DATE COMPL 10/21/	ETED
	PROVIDER OR SUPPLIER		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE ESTDALE CT 10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	and investigated indicated no furt available to indic involving clients investigated. The client to client at investigated on t investigation for 3) On 9/25/14 at BDDS (Bureau or Disabilities Servaccident/injury r 9/25/14 and invertiewed. A BD indicated "staff vin the shower thing that there was a soft her upper left fresh, a dark pur inches across." "staff asked [Clieshe couldn't tell from. There have at the home, and Developmental I will check with the to clarify. She disometimes when the QDDP and the was on call." The "QDDP will followed."	#2 and #7 were Administrator indicated buse should be he facility formal's mat. 3:45 PM, the facility's of Developmental ices) and internal eports from 6/1/14 to stigations were DS report dated 7/12/14 was assisting [Client #4] is afternoon and noted large bruise on the inside thigh. The bruise looks ple, and is about 3.5 The report indicated ent #4] how she got it but them where it came is been no reported falls QDDP (Qualified Disability Professional) he workshop on Monday oes bump into walls walking. Staff notified he Residential Nurse who he report indicated					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G496	A. BUIL	DING	NSTRUCTION 00	(X3) DATE COMPL 10/21	ETED
		130490	B. WING			10/21/	2014
NAME OF F	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
DONA VI	STA PROGRAMS I	NC			ESTDALE CT 10, IN 46902		
					10, 114 40302		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E		(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
		e was a fall or any					
		wall etc. Residential					
		her Primary care					
	physician (sic) an						
		n. Staff will monitor the					
		and document if [Client					
	#4] has any pain	=					
]						
	The "Investigation	on of Injury of Unknown					
		12/14 indicated Client #4					
		cross dark purple bruise					
		er left thigh." The					
		icated "Consumer					
	(Client #4) has v	ery little verbal skills					
	and when asked	how she got it she could					
	not tell them who	ere." The investigation					
	indicated "spoke	with Residential Q					
	(Qualified Intelle	ectual Disabilities					
	Professional) and	d staff regarding the					
	bruise. There wa	as no fall reported nor					
	did any of them	know about the bruise					
	until it was notic	ed that day." The					
	investigation ind	icated "spoke with					
	[Supervisor of D	ayprogram] in regards to					
	this and she had	no knowledge of [Client					
		mping into anything that					
		ising." The investigation					
		which residential DSPs					
		rofessionals) were					
		e interviews of staff were					
	not included in the	he investigation.					
	0 10/15/14 : 3	25 DM 41 C '''					
		:35 PM, the facility					
	Administrator in	dicated injuries of					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE : COMPL	
ANDILAN	or correction	15G496		LDING		10/21/	
		100100	B. WIN		DDDEGG CITY OT THE ZID CORE	10/21/	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ESTDALE CT		
BONA VI	STA PROGRAMS I	NC			10, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		· · · · · · · · · · · · · · · · · · ·		IAG	Dia teliate 1 y		DATE
	investigated.	should be thoroughly					
	investigated.						
	On 0/25/14 at 11	.25 ANA - maniana afala a					
		:35 AM, a review of the					
	facility policy or						
	Violations of Inc	C					
	,	ted "In order to protect					
	_	are of persons served,					
		prohibits the abuse of					
		et, exploitation or					
		any individual or					
		ndividual's rights by					
		ents delivering services					
		agency." The policy					
		porting" that "it is the					
		any employee who					
	_	edge of an alleged case					
	-	y, exploitation or					
		vidual rights to report it					
	•	bally and/or in writing to					
		if the President is					
		Director, Human					
	Resources."						
	0.2.2(a)						
	9-3-2(a)						

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Event ID:

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G496		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING (COMPLETED (COMPLETE			
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE /ESTDALE CT	
BONA VI	STA PROGRAMS I	NC		MO, IN 46902	
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
W000153	of mistreatment, n injuries of unknow immediately to the officials in accordathrough established. Based on record the facility failed incidents of clier state agency BDD Developmental II of 4 sampled canditional client state law. Findings include On 9/25/14 at 3:4 BDDS (Bureau of Disabilities Servaccident/injury researched)	nsure that all allegations eglect or abuse, as well as a source, are reported administrator or to other ance with State law and procedures. Treview and interview, at to report 2 of 2 at to client abuse to the DS (Bureau of Disabilities Services) for lients (#1) and 1 (#7) in accordance with	W000153	Toensure that established agency policies and procedures for incident reportingis being implemented and executed written, the following corrective action(s)will be implemented: 1) All staff located at 233 WestdaleCourt (Westdale group home) will be re-train on the agency Personnel Policiesand Procedures, Pol III:13: Incident Reporting. Completed Record of Traini will be obtained and submit upon completion of training	ned icy ngs ted

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Event ID:

W4Z511

Facility ID: 001010

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED	
		15G496	B. WIN			10/21/2014	
			D. (111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	S.			ESTDALE CT		
BONA VI	STA PROGRAMS I	NC			10, IN 46902		
(V4) ID	CLIMMA DAY O	TATEMENT OF DEFICIENCIES		ID	-,	(V5)	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE	
1710		•	+	1710	Defeute Annoudin A feu Dee		
		t report dated 7/23/14			Referto Appendix A for Reco		
	_	nt #1] was sitting on			of Training form to be used.		
	_	tv (television) and other					
	consumer was va	acuuming and tired (sic)					
	to move [Client:	#1] and she wouldn't so					
	other consumer l	nit her on her left upper					
		dness and may cause					
	bruising." There	•					
		available for review					
		the incident was reported					
	to BDDS.	the merdent was reported					
	ա հերեծ.						
	A :	4					
		dent/incident report dated					
		"[Client #7] was pushed					
		her left side. There is no					
	bruising shown a	at this time." There was					
	no further docun	nentation available to					
	indicate this inci	dent was reported to					
	BDDS.	•					
	Both reports indi	icated "REPORT MUST					
	BE TURNED IN						
	BUSINESS DA'						
	ACCIDENT/ING						
	SUPERVISOR A						
		eport indicated the					
	initials of the fol	lowing as have reviewed					
	the report: Super	visor, Agency Nurse,					
	QDDP (Qualifie	d Developmental					
	` ` `	essional), Vice President,					
		es, Safety Manager,					
		tor, and President. No					
	1	tation was available for					
	review which inc	dicated the incidents of					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING	00	COMPLETED			
		15G496	A. BUILDING B. WING	10/21/2014			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2333 WESTDALE CT KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	client to client ab state agency BDI	buse were reported to the DS.					
	PM, the facility a all incidents of co to be reported an administrator ind client to client ab	iew on 10/15/14 at 2:35 administrator indicated lient to client abuse are d investigated. The licated both incidents of buse involving clients #1 live been reported to					
W000154	483.420(d)(3) STAFF TREATME The facility must h alleged violations a investigated.	ave evidence that all	W000154		11/20/2014		
	the facility failed investigate an inj for 1 of 1 BDDS	jury of unknown origin	W000154	Toensure that established agency policies and procedures for investigation are being implemented and executed as written, the following corrective action	1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00		00	COMPLETED	
		15G496	A. BUI. B. WIN			10/21/	2014
			P. 1111		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			/ESTDALE CT		
BONA VI	STA PROGRAMS	INC			MO, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	· ·		DATE
		of unknown origin for 1			willbe implemented:		
	of 4 sampled cli	ents (#4).			1) Toensure that all		
					incidents of significant injur	ry,	
		review and interview,			injury of unknown origin,		
	the facility failed	• •			andpeer-to-peer aggression	are	
	_	l with major injury for 1			properly documented and		
	additional client	(#7).			investigated. Any incidents		
					be reported to the Residenti	al	
	Based on record	review and interview,			Services Coordinator. The		
	the facility failed	d to thoroughly			ResidentialServices		
	investigate clien	t to client abuse for 2 of			Coordinator will complete t	he	
	2 incidents of cl	ient to client abuse			appropriate documentation	and	
	reviewed for 1 o	of 4 sampled clients (#1)			maintainfor record keeping		
	and 1 additional	client (#7).			purposes. Refer to Appendix	D	
					to review forms that will be		
	Findings include				implemented occurrences o		
					eitherincident.	,	
	1) On 9/25/14 at	t 3:45 PM, the facility's			2) Toensure that incident	ts	
	l '	of Developmental			have been reported and		
	l '	vices) and internal			investigated in the manner		
		reports from 6/1/14 to			asoutlined in agency policie	s,	
		viewed. A BDDS report			all investigations packets,	,	
		dicated "staff was			regardless of type, will have	an	
		#4] in the shower this			investigation process check		
		oted that there was a large			included. The checklist will		
		side of her upper left			becompleted by the		
		se looks fresh, a dark			Residential Services		
	_				Coordinator as he/she is		
	purple, and is about 3.5 inches across." The report indicated "staff asked [Client				conducting theinvestigation		
	_	-			_	.	
		it but she couldn't tell			Upon the conclusion of the		
		nme from. There have			investigation, all		
	1 -	I falls at the home, and			investigationmaterials	,	
		ed Developmental			including the checklist will	be	
l	L Disabilities Prof	Pessional) will check with	I		given to the Vice President		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G496		(X2) MULTIPLE CON A. BUILDING B. WING	00	COMPLETED 10/21/2014		
	PROVIDER OR SUPPLIER ISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2333 WESTDALE CT KOKOMO, IN 46902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	the workshop on Monday to clarify. She does bump into walls sometimes when walking. Staff notified the QDDP and the Residential Nurse who was on call." The report indicated "QDDP will follow up with her workshop supervisor on Monday to determine if there was a fall or any bumps with the wall etc. Residential Nurse will notify her Primary care physician (sic) and follow any instructions given. Staff will monitor the size of the bruise and document if [Client #4] has any pain." The "Investigation of Injury of Unknown Origin" dated 7/12/14 indicated Client #4 had a "3.5 inch across dark purple bruise on inside of upper left thigh." The investigation indicated "Consumer (Client #4) has very little verbal skills and when asked how she got it she could not tell them where." The investigation indicated "spoke with Residential Q (Qualified Intellectual Disabilities Professional) and staff regarding the bruise. There was no fall reported nor did any of them know about the bruise until it was noticed that day." The investigation indicated "spoke with [Supervisor of Dayprogram] in regards to this and she had no knowledge of [Client #4] falling or bumping into anything that would cause bruising." The investigation did not indicate which residential DSPs		ofResidential Services for review. The Vice President Residential Serviceswill sign-off on the checklist and accompanying materials on all items havebeen reviewed and approved. Refer to Appendix E to review investigation process check	of d ce		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE COMPL		
THIND I LIMIT	or conduction	15G496		LDING		10/21/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ESTDALE CT		
BONA VI	STA PROGRAMS I	NC			10, IN 46902		
(X4) ID		UMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		rofessionals) were		IAG	Dia lettike 1		DATE
	`	e interviews of staff were					
	not included in t						
	not included in t	ne mvestigation.					
	On 10/15/14 at 2	2:35 PM, the facility					
	Administrator in	dicated injuries of					
	unknown origin	should be thoroughly					
	investigated with	n staff interviews.					
	· /	3:45 PM, the facility's					
	BDDS (Bureau of Developmental						
	Disabilities Services) and internal						
		eports from 6/1/14 to					
		viewed. A BDDS report					
		icated "[Client #7] was					
	visiting the [mus	_					
		staff was walking					
	_	oit. Staff was assisting					
	_	oing up a ramp when					
		ed a step and fell her face on part of the					
	, ,	ooked like fake rock).					
	The EMT (emer	· · · · · · · · · · · · · · · · · · ·					
	, ,	re called and she was					
	· · · · · · · · · · · · · · · · · · ·	staff to [hospital] via					
	ambulance. Hou						
	residential nurse	_					
		The report indicated					
		a CT (computerized					
	_ =	n, and required 6 stitches					
		the bottom of her lip up					
		has two fractures, one in					
		and one in the sinus					
		expected to heal on their					
	cavity. Bom are	enpocted to hear on their					

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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG WILL THE PROPRIATE OF THE OWN." The report indicated "[Client #7] has been put on antibiotics for the next 6 weeks, has to have soft foods only during this time, and cannot smoke or blow her nose. The attending physician did not order any follow up at this time, and wrote a prescription of nicotine patches." The report indicated "staff will continue to monitor [Client #7]'s injuries and report any changes in them to the
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Own." The report indicated "[Client #7] has been put on antibiotics for the next 2-3 days, cannot wear her dentures for the next 6 weeks, has to have soft foods only during this time, and cannot smoke or blow her nose. The attending physician did not order any follow up at this time, and wrote a prescription of nicotine patches." The report indicated "staff will continue to monitor [Client #7]'s injuries and report any changes in them to the
BONA VISTA PROGRAMS INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Own." The report indicated "[Client #7] has been put on antibiotics for the next 2-3 days, cannot wear her dentures for the next 6 weeks, has to have soft foods only during this time, and cannot smoke or blow her nose. The attending physician did not order any follow up at this time, and wrote a prescription of nicotine patches." The report indicated "staff will continue to monitor [Client #7]'s injuries and report any changes in them to the
BONA VISTA PROGRAMS INC (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG Own." The report indicated "[Client #7] has been put on antibiotics for the next 2-3 days, cannot wear her dentures for the next 6 weeks, has to have soft foods only during this time, and cannot smoke or blow her nose. The attending physician did not order any follow up at this time, and wrote a prescription of nicotine patches." The report indicated "staff will continue to monitor [Client #7]'s injuries and report any changes in them to the
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Own." The report indicated "[Client #7] has been put on antibiotics for the next 2-3 days, cannot wear her dentures for the next 6 weeks, has to have soft foods only during this time, and cannot smoke or blow her nose. The attending physician did not order any follow up at this time, and wrote a prescription of nicotine patches." The report indicated "staff will continue to monitor [Client #7]'s injuries and report any changes in them to the
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) Own." The report indicated "[Client #7] has been put on antibiotics for the next 2-3 days, cannot wear her dentures for the next 6 weeks, has to have soft foods only during this time, and cannot smoke or blow her nose. The attending physician did not order any follow up at this time, and wrote a prescription of nicotine patches." The report indicated "staff will continue to monitor [Client #7]'s injuries and report any changes in them to the
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and wrote a prescription of nicotine patches." The report indicated "staff will continue to monitor [Client #7]'s injuries and report any changes in them to the
patches." The report indicated "staff will continue to monitor [Client #7]'s injuries and report any changes in them to the
continue to monitor [Client #7]'s injuries and report any changes in them to the
and report any changes in them to the
nurse. If needed, follow up with her
primary care physician will be done to
check the progress of any
injuries/healing, or any complaints that
[Client #7] has." No further documentation was available for review
which indicated the fall was investigated
to indicate whether staff were following
Client #4's fall plan at the time of the fall
and/or whether Client #4's fall risk plan
was adequate to prevent recurrent falls.
A BDDS report dated 8/8/14 indicated
"[Client #7] was out in the community
with her housemates and staff, having a
picnic and taking a walk around the
downtown area. During the walk, [Client
#7] tripped over a curb and fell, scraping
her elbow. Staff administered first aid
and continued walking for a bit. About
20 minutes later, she began to collapse, at
which time she was assisted to the
ground." The report indicated "the

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G496		ĺ	LDING	NSTRUCTION 00	(X3) DATE COMPL 10/21	ETED	
	PROVIDER OR SUPPLIER			STREET A	ODDRESS, CITY, STATE, ZIP CODE ESTDALE CT 10, IN 46902	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	and she was take (emergency room nurse and QDDF Developmental I were notified im indicated all labs normal limits at Client #7 "had a which showed the present that the I consistent with a elbow." The repup with orthoped recommended for [Client #7] is to except when shoup with [orthoped recommended the with [doctor] in that [Client #7] It last month the number point in time, base a medical condition contributing to he scheduled to see (ophthalmologis am. This visit she determine wheth cause of these far normally steady.	Disabilities Professional) mediately." The report and x-rays were within the hospital except x-ray of her right elbow hat there was some fluid Dr. (doctor) felt may be hairline fracture of her ort indicated "A follow lic [doctor] is or 4 days from now. wear a sling at all times wering until she follows dic doctor]. It is also hat [Client #7] follow up days. Due to the fact has fallen 2 times in the harse is asking her The evaluation. At this hased on the tests that were here anything that points to hion that would be here falling. She is here for the fact has fallen 2 times in the harse is asking her here anything that points to hion that would be here falling. She is here for the fact has fallen 2 times in the harse is asking her here anything that points to hion that would be here falling. She is here falling. She is					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G496		A. BUILD		NSTRUCTION 00	(X3) DATE COMPL 10/21/	ETED	
		130490	B. WING			10/21/	2014
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
DONA M		N/C			ESTDALE CT		
BONA VI	STA PROGRAMS I	NC		KUKUW	IO, IN 46902		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ear infection or fluid					
	•	esent." No further					
		vas available for review					
		the fall was investigated					
		ner staff were following					
	Client #4's fall p	lan at the time of the fall					
	and/or whether (Client #4's fall risk plan					
	was adequate to	prevent recurrent falls.					
	On 10/15/14 at 4	:10 PM, record review					
	indicated Client #7's diagnoses included,						
	but were not limited to, intellectual						
	disabilities, seizu						
	•	excessive water on the					
		eview indicated Client					
	· ·	plan dated 11/26/13 and					
		/2014 which indicated					
		nosis of Hydrocephalus					
	_	use her experience poor					
		• •					
		e depth perception. She					
		walking on uneven, slick					
		faces. She does not like					
	_	inter time when snow					
		e ground. She will often					
		grass and find a path					
		nce no matter how much					
		alk to her destination."					
	The fall risk plar	indicated "[Client #7]					
	has a rolling wal	ker now to assist her in					
	being stable whi	le walking. She is to use					
	this whenever sh	e is outside of the					
	home."						
	On 10/15/14 at 1	2:25 PM, the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	COMPL		
ANDILAN	OF CORRECTION	15G496	A. BUI	LDING	00	10/21/	
		130490	B. WIN			10/21/	2014
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
BONA VI	STA PROGRAMS I	NC			'ESTDALE CT 1O, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		dicated Client #7's team					
		at medical causes of falls					
		eported fall. The					
		dicated Client #7 had her					
	_	ecked, has had physical					
		seen her primary care					
	1 * *	Administrator indicated					
		vestigations of either of					
		with major injury in					
	regards to the whether staff were						
	following Client #7's fall risk plan and/or						
	whether the fall risk plan was adequate to						
	prevent recurrent falls.						
	3) On 9/25/14 at	3:45 PM, the facility's					
		of Developmental					
	,	ices) and internal					
		eports from 6/1/14 to					
	1	riewed. On 9/25/14 at					
		ility's BDDS (Bureau of					
	•	Disabilities Services) and					
		/injury reports from					
		were reviewed. An					
		/incident report dated					
		d "[Client #1] was sitting					
		ng tv (television) and					
		was vacuuming and tired					
	(sic) to move [C]	-					
		r consumer hit her on her					
		There is redness and may					
		There was no further					
		vailable for review to					
		lent was thoroughly					
	investigated to ir	ndicate whether staff					

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G496	A. BUILDING B. WING			COMPLETED 10/21/2014	
	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE ESTDALE CT IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) AVIOR SUPPORT Plans.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	An internal accided 7/2/14 indicated into the wall on he bruising shown a no further document indicate this incide investigated to impushed Client #7 whether staff were support plans. During an intervipulation of client and incidents of client to client and and #7 should had investigated. The the facility plann	lent/incident report dated "[Client #7] was pushed her left side. There is no het this time." There was hentation available to dent was thoroughly hedicate which client into the wall and here following all behavior liew on 10/15/14 at 2:35 Administrator indicated hient to client abuse are investigated. The dicated both incidents of house involving clients #1 have been thoroughly he Administrator indicated hed to investigate client he the formal template					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G496	B. WING		10/21/2014
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUPPLIER	S.		/ESTDALE CT	
BONA VI	STA PROGRAMS I	NC		MO, IN 46902	
				T	(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
TAG	REGULATORT OR	ESC IDENTIFTING INFORMATION)	IAG		DATE
W000157	483.420(d)(4)				
	STAFF TREATME	ENT OF CLIENTS			
		tion is verified, appropriate			
	corrective action r	nust be taken.			11/20/2011
			W000157	Toensure approval that	11/20/2014
		review and interview,		recurrence of falls with	
	the facility failed	l to develop appropriate		major injury are prevente	d
	corrective action	to prevent recurrence of		whenpossible, the followin	g
	a fall with major	injury for 1 additional		corrective action(s) will be	,
	client (#7).			implemented:	
				1) Inthe event of a fall w	ith
	Findings include	:		significant injury, the fall w	ill
				be reported to the Residentia	
	On 9/25/14 at 3	:45 PM, the facility's		Services Coordinator. The	
	BDDS (Bureau o	of Developmental		Residential Services	
	Disabilities Serv	ices) and internal		Coordinator willthen ensure	
	accident/injury r	eports from 6/1/14 to		that all incidents of significa	
	9/25/14 were rev	riewed. A BDDS report		injury, injury of unknown	****
	dated 7/5/14 ind	icated "[Client #7] was		origin, and peer-to-peer	
	visiting the [mus	seum] with other		aggression are properly	
	housemates and	staff was walking		documented and investigate	d
	through an exhib	oit. Staff was assisting		TheResidential Services	ч.
	another client go	oing up a ramp when		Coordinator will complete the	he
	[Client #7] miss	ed a step and fell		appropriate documentationa	
	forward, hitting	her face on part of the		maintain for record keeping	
	_	ooked like fake rock).			
	The EMT (emer			purposes. Referto Appendix	
	· ·	re called and she was		to review forms that will be	
	· ·	staff to [hospital] via		implemented occurrences o	J
	aunsported with	suit to [nospital] via		eitherincident.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	IULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		15G496	B. WIN			10/21/	2014
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	R		2333 W	ESTDALE CT		
BONA VI	ISTA PROGRAMS	INC		KOKOMO, IN 46902			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	<u> </u>	R LSC IDENTIFYING INFORMATION)		TAG			DATE
		use manager and			2) TheResidential Servic	es	
	residential nurse				Coordinator will report		
	_	The report indicated			findings from investigations	5	
	_	a CT (computerized			ofsignificant injury to the		
		n, and required 6 stitches			Residential House Manager		
		n the bottom of her lip up			and Residential Nurse. These		
		e has two fractures, one in			staff members will in turn u		
	1	and one in the sinus			this information to determin	e	
	cavity. Both are	e expected to heal on their			what, ifany, medical		
	own." The report indicated "[Client #7]				intervention is needed.		
	has been put on antibiotics for the next				3) If the fall is a result of	a	
	2-3 days, cannot	t wear her dentures for the			change in medical condition	١,	
	next 6 weeks, ha	as to have soft foods only			the respective client's Fall P	lan	
	during this time,	, and cannot smoke or			will be updated and revised	to	
	blow her nose.	The attending physician			include measures to prevent		
	did not order an	y follow up at this time,			futurefalls. All staff working		
		scription of nicotine			the home will be retrained o	- I	
	-	eport indicated "staff will			the revised FallPlan.		
	_	nitor [Client #7]'s injuries					
		hanges in them to the					
		d, follow up with her					
		ysician will be done to					
	check the progre						
		or any complaints that					
	[Client #7] has.						
	A RDDS report	dated 8/8/14 indicated					
	-	s out in the community					
		nates and staff, having a					
		g a walk around the					
	_	During the walk, [Client					
		· · · · · ·					
		a curb and fell, scraping					
		f administered first aid					
	I and continued w	alking for a bit. About					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	15G496	A. BUI	LDING	00	10/21	
		100480	B. WIN			10/21/	20 I '1
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
BONA VI	STA PROGRAMS I	NC			/ESTDALE CT ИО, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	·	she began to collapse, at					
		vas assisted to the					
		port indicated "the					
		called as a precaution,					
		en to [hospital] ER					
	, ,	n) as a precaution. The					
	nurse and QDDF	` -					
		Disabilities Professional)					
		mediately." The report					
	indicated all labs and x-rays were within						
	normal limits at the hospital except						
	Client #7 "had a x-ray of her right elbow						
		at there was some fluid					
	•	Or. (doctor) felt may be					
		hairline fracture of her					
		ort indicated "A follow					
	up with orthoped	= =					
	recommended for	or 4 days from now.					
	[Client #7] is to	wear a sling at all times					
	except when sho	wering until she follows					
	up with [orthope	dic doctor]. It is also					
		at [Client #7] follow up					
		5 days. Due to the fact					
	that [Client #7] h	nas fallen 2 times in the					
	last month the nu	ırse is asking her					
	physician for a P	T evaluation. At this					
	point in time, ba	sed on the tests that were					
	ran, we do not se	ee anything that points to					
	a medical condit	ion that would be					
	contributing to h	er falling. She is					
	scheduled to see	[doctor]					
	(ophthalmologis	t) on 8/11/14 @ (at) 10					
	am. This visit sh	nould be able to					
	determine wheth	er or not her vision is the					
					l		

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) MULTIPLE CONSTRUCTION (x3) DATE A DUBLING 00 COMPI				
15G496				LDING		10/21/	
		100400	B. WIN		Paragram and the grant control	10/21/	2014
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE ESTDALE CT		
BONA VISTA PROGRAMS INC					10, IN 46902		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		lls. [Client #7]'s gait is					
		" The report indicated					
	· ·	ere checked at the ER					
		ear infection or fluid					
	accumulation pro	esent."					
		:10 PM, record review					
		#7's diagnoses included,					
		ited to, intellectual					
	disabilities, seizure disorder, and						
	hydrocephalus (excessive water on the						
	/	eview indicated Client					
		plan dated 11/26/13 and					
		1/2014 which indicated					
	_	nosis of Hydrocephalus					
	and Cataracts cause her to experience						
	_	l little depth perception.					
		ance walking on uneven,					
	_	d surfaces. She does not					
	like walking in the winter time when snow and ice are on the ground. She will						
	often refuse to walk on grass and find a						
	path with staff assistance no matter how						
	much further it is to walk to her						
	destination." The fall risk plan indicated						
	"[Client #7] has a rolling walker now to						
	assist her in being stable while walking.						
		whenever she is outside					
		o further documentation					
	was available to	indicate corrective					
	action was devel	oped to prevent					
	recurrence of fal	ls with injury after Client					
	#7's 7/5/14 repor	ted fall.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC	00	(X3) DATE SURVEY COMPLETED			
15G496		A. BUILDING B. WING	BUILDING 10/21/2014				
NAME OF B	DROWIDED OR CUIDN IED	STREET ADDRESS, CITY, STATE, ZIP CODE					
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC		2333 WESTDALE CT KOKOMO, IN 46902					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	On 10/15/14 at 12:25 PM, the Administrator indicated Client #7's team wanted to rule out medical causes of falls after the 8/8/14 reported fall. The Administrator indicated Client #7 had her ears and eyes checked, had physical therapy, and has seen her primary care physician. The Administrator indicated there was no further documentation to indicate corrective action after Client #7's fall with major injury reported on 7/5/14 and 8/8/14 in regards to updating Client #7's fall risk plan on ambulating on community outings or additional training for staff. 9-3-2(a)						
W000368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, the facility failed to ensure medications were administered as prescribed by physician's orders for 1 of 4 sampled clients (#2) and 1 additional client (#8). Findings include:	W000368	Toensure that all medications are administered as prescribed by physicians'orders, the following corrective action will be implemented: 1) Allstaff located at the location of 2333 Westdale				

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	of correction identification number: 15G496	A. BUILDING B. WING (X3) DATE SURV COMPLETED 10/21/2014				
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2333 WESTDALE CT KOKOMO, IN 46902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRI PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ection (X5) ULLD BE PROPRIATE COMPLETION DATE			
	On 9/25/14 at 3:45 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) and internal accident/injury reports from 6/1/14 to 9/25/14 were reviewed. A BDDS report dated 9/17/14 indicated "During the 8pm narcotic count, staff noticed that [Client #2]'s 8 AM dose of Clonazepam (anti-anxiety) 1mg (milligram) was still in the bubble pack. Residential Nurse notified of the missed dose and the primary care physician's office was also notified. [Client #2] was to continue on with normal dosing, and was given his 8 PM dose." The report indicated "[Client #2] had slightly more anxiety throughout the day reported, but did not have any significant behaviors." A BDDS report dated 9/7/14 indicated "staff was packing [Client #2]'s medications so that he could go home for the afternoon/evening, and while packing his 8PM medications, staff noticed that he was out of his Cogentin (used to counter side effects of other medications) 2mg. He takes this medication twice a day, at 8am and 8pm. The staff notified [Client #2]'s primary care physician." The report indicated "[Client #2] will also miss his 8am dose on 910/2014. Residential Nurse will call the pharmacist in the morning to find out if this is a refill	Court (Westdale group will be receive re-train the agency medication administration policy CompletedRecord of will be obtained and supon completion of training forms to be is the intent that this to will prevent future medicationerrors for the affected as well as all clients residing in the supon completion of training forms to be is the intent that this to will prevent future medicationerrors for the affected as well as all clients residing in the supon completion of training forms to be is the intent that this to will prevent future medicationerrors for the affected as well as all clients residing in the supon completion of training forms to be is the intent that this training forms to be is the intent that this training forms to be is the intent that this training forms to be is the intent that this training forms to be is the intent that this training forms to be is the intent that this training forms to be is the intent that this training forms to be is the intent that this training forms to be is the intent that this training forms to be is the intent that this training forms to be is the intent that this training forms to be is the intent that this training forms to be is the intent that this training forms to be is the intent that this training forms to be is the intent that this training forms to be is the intent that this training forms to be is the intent that the intent that this training forms to be intent that the in	Trainings ubmitted aining. or Record oe used. It raining the clients other			

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	OO	COMPL		
and Plan of Correction identification number: 15G496			LDING	00	10/21/			
100490		B. WING				2014		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
BONA VISTA PROGRAMS INC			2333 WESTDALE CT KOKOMO, IN 46902					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE	
	issue, etc."							
	A BDDS report of "[Client #8] miss Diazepam (anti-a was noticed at 1" the narc (narcotinurse was notice (primary care ph there would be not the started the mass and the started the started the mass and the started the mass and the started the mass and the started the started the mass and the started the started the mass and the started the started the started the mass and the started the s	doctor said there may be for and or (sic) anxiety, other adverse side intinue with next dose as 2:25 PM during an IDP (Qualified bilities Professional) #2 and #8 medications in administered according						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G496		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/21/2014			
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2333 WESTDALE CT KOKOMO, IN 46902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	

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